

Pediatrics & Parents

The newsletter for people who care for children

Richard J. Sagall, MD, Editor

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Where Does the Time Go?

Children ten to nineteen years old spend an average of one hour playing video games on weekdays and one and a half hours on weekends. In this 2002-3 study, 36% of the 1491 children surveyed (80% of the boys and 20% of the girls) played video games on at least one weekday and one weekend day during the week of the study. The information was collected during the school year.

The game players spent 30% less time reading and 34% less time doing homework than the non-gamers. The amount of time spent interacting with friends and parents, playing sports, or participating in leisure activities, was the same in both groups.

School responsibilities (reading and homework) suffer when children play video games. Parents should consider monitoring the amount of time their children spend playing video games, especially if their grades decline.

Archives of Pediatrics, 7/07

Strep Throat – A Family Affair?

Almost everyone knows someone who has had group A [beta]-hemolytic streptococcal (GABHS) pharyngitis, better known as strep throat. While usually not life-threatening, strep throat is uncomfortable and inconvenient for both a child who has it and her parents who have to deal with it. And, it's quite contagious.

Sometimes a doctor recommends treating the entire family of a child with strep throat because by treating asymptomatic family members, their chances of contracting a strep infection may be lessened. Or are they?

In a study published earlier this year in *The Pediatric Infectious Disease Journal*, the siblings of 1181 children with strep throat were treated either prophylactically with one of two antibiotics (penicillin or cephalosporins) or given no prophylactic treatment. Although the children in the prophylactic treatment group developed slightly fewer strep throats than those who had received no preventative treatment, the rates in both groups were low (3% vs. 5%).

Lead researcher Hideaki Kikuta, MD, PhD of Hokkaido University concluded that – due to the low incidence of siblings developing strep throat, the costs associated with administering antibiotics in non-strep-infected individuals, and the uncertainty of the antibiotic targeting the right flora – prophylactic treatment of strep throat is not warranted.

The Pediatric Infectious Disease Journal, 2/07

Pertussis, or whooping cough, is a respiratory infection that has been on the rise in recent years. This disease, characterized by paroxysms of coughing, is commonly thought of as a childhood illness, and children receive a series of immunizations to prevent infection. Over the last few years pertussis has been increasingly reported in the adolescent and adult population. The resurgence of this contagious infection has heightened interest in addressing prevention among this older group.

Pertussis is caused by the bacteria *Bordetella pertussis*, a rod-shaped organism that produces a toxin, as well as other products. The toxin appears to inhibit the action of the respiratory tract cilia, the fine hair-like structures that clear the breathing passages. This inhibits the ability of the respiratory tract from clearing secretions, which induces excessive coughing. In addition, the bacteria generate an inflammatory reaction that causes local reactions that may affect the respiratory tract.

Infection is spread by contaminated respiratory droplets released into the air. Pertussis is highly contagious, with a reported infection rate of greater than 80%. Infected individuals are most likely to be contagious early on in the disease, perhaps up to 21 days. Although there may be a carrier state, it does not appear to be important in sustaining the disease in the community.

Once exposed, the individual develops signs of the illness within seven to ten days, although the incubation period can be longer. The first phase of the disease, the catarrhal phase, manifests symptoms very like the common cold. The patient may be sneezing, have a runny nose, a low-grade fever and a mild cough.

After one to two weeks, the patient begins to demonstrate bursts of many rapid coughs, the paroxysmal phase. The prolonged coughing, which is productive of thick sputum, induces some patients to follow the spell with a "whooping" inhalation, hence, the name. Infants are less likely to exhibit the "whoop," however. These bouts of coughing can be so fearsome that the patient becomes exhausted or cyanotic. Sometimes the coughing is followed by vomiting. The paroxysms of coughing are more likely to occur at night. This phase lasts one to six weeks, but can linger for up to ten weeks.

The paroxysmal phase is followed by the convalescent phase, during which the patient gradually recovers. Still, the individual is prone to excessive coughing with other respiratory infections for months afterwards.

The diagnosis of pertussis is usually made based on the history and physical examination. It is extremely difficult to isolate the organism. Other tests can aid in the diagnosis, such as polymerase chain reactions or serology, but none of these tests are easily accessible. Other aids to diagnosis might include an elevated lymphocyte count or a history of exposure.

The infant population is most at risk for severe complications from pertussis infection. Many infants must be hospitalized because of complications. Most commonly, patients are susceptible to a secondary bacterial pneumonia, which can be quite serious in the infant population. Other complications include neurologic symptoms, such as seizure and encephalopathy (a diffuse disorder of the brain). These are most likely caused by a lack of oxygen from coughing or pneumonia. Pertussis infection can also result in otitis media (ear infection) and dehydration.

Management of the infection is usually supportive, maintaining hydration and nutrition. Antibiotics do offer some benefit, decreasing the likelihood of transmission and possibly mitigating the course of the disease. All close contacts need a course of antibiotics. For those not fully immunized, vaccine status should be updated where feasible.

The immunization program has been in effect for years. In the 1990s, an acellular, more purified, preparation of the pertussis portion of the DTP (diphtheria/tetanus/pertussis) vaccine was substituted to minimize side effects. Immunizations are scheduled at two, four, six, and 15-18 months of age with a fifth booster dose at school entry age between ages four to six years.

Immunity is not life long however, and disease resistance begins to wane five to ten years after the last vaccination. This leaves the adolescent and adult population without adequate immunity. These individuals become susceptible to the infection, although adults and adolescents generally have less severe symptoms and are less likely to manifest the "whoop." The rate of complications for this population is low, but the infection can lead to lost work or school days.

More importantly, adults and adolescents become an important reservoir for the disease, exposing others to the infection. This is particularly dangerous for the infants exposed, who are possibly only partly immunized and who suffer the greatest risk of morbidity and mortality from pertussis.

Until recently, however, the available pertussis vaccinations were not certified for use in adolescents and adults. In 2005, two new preparations were approved to offer immunization to older groups. Boostrix is a combined vaccine of tetanus, diphtheria and acellular pertussis, or Tdap, and is licensed for use in 10-18 year olds. Adacel has been approved for 11-64 year olds.

Approval of these two vaccines, along with the rising occurrence of pertussis, prompted the Advisory Committee on Immunization Practices (ACIP) to review the recommendations for pertussis vaccinations. This advisory group released new provisional guidelines for vaccine recommendations. The presently available booster for Td, or Tetanus/diphtheria, should be replaced by Tdap. This will afford protection for the adult population, as well as minimize the transmission of pertussis infection from adults to susceptible infants.

In addition, adults who will come in contact with infants should have this booster at least one month ahead of time. The booster can be given on top of the old booster if more than two years has elapsed since the old booster was given.

Children at age 11-12 should receive immunization with Tdap, assuming their last immunization was at least five years before. Additionally, women who might become pregnant or who are immediately postpartum should be vaccinated with Tdap. The primary series of immunizations during childhood remain the same.

Vaccinations do result in some side effects, but these have been reduced with the use of the more purified pertussis preparation. Still, 20-40% of children will develop local, minor effects such as redness, swelling and pain at the injection site. A small minority of children, roughly 1%, may demonstrate more serious side effects, such as high fevers and seizures.

The vaccine should not be used in individuals who have shown an allergic reaction to the shot in the past or in those who have had an unexplained encephalopathy within seven days of a prior pertussis vaccination.

The vaccination program effectively reduced pertussis during the last part of the 20th century. As immunity has decreased in the population, however, pertussis has become a more frequent infection. In 2004, 25,827 cases were reported, up from a low of 1020 cases in 1976. According to the CDC, 60% of cases occurred in those aged 11 and older. To reduce the risk of infection for the population, careful consideration should be given to implementing the updated suggestions by the ACIP. Discuss the issue with the pediatrician or family doctor to decide what might be best for the family.

Marilyn Moss is a retired New Haven physician. After retiring from Yale University, she has begun to pursue an interest in writing about health-related issues. Dr. Moss resides in Woodbridge, CT with her husband, also a physician, and her two children.

Backpack Safety

The American Occupational Therapy Association has some tips to help your children avoid backpack-related health problems:

1. Never let a child carry more than 15% of his or her body weight. This means a child who weighs 100 pounds shouldn't wear a backpack heavier than 15 pounds.
2. Load heaviest items closest to the child's back and arrange books and materials to prevent them from sliding.
3. Always wear both shoulder straps. Wearing only one strap can cause a child to lean to one side, curving the spine and causing pain or discomfort.
4. Select a pack with well-padded shoulder straps. Too much pressure on shoulders and necks can cause pain and tingling.
5. Adjust the shoulder straps so that the pack fits snugly to the child's back. The bottom of the pack should rest in the curve of the lower back, never more than four inches below the child's waistline.
6. Wear the waist belt, if the backpack has one, to help distribute the pack's weight more evenly.
7. Check what your child carries to school and brings home to make sure the items are necessary to the day's activities.
8. If the backpack is too heavy, consider using a book bag on wheels if your child's school allows it.
9. Choose the right size pack for your child's back as well as one with enough room for necessary school items.
10. If a student is experiencing back pain or neck soreness, consult your doctor or an occupational therapist.

The Alarming Trend of Teen Girl Smoking

By Marta De Borba-Silva, MPH

Smoking will eventually kill more teens than all other combined methods of death. Large-scale studies have firmly established that one in two life-long smokers dies from smoking, half while in middle age. With each cigarette smoked, seven minutes of life is lost. Smoking diseases such as lung cancer with low cure rates tend to be very painful ways to die. So, why are so many teenage girls – as compared to teenage boys – taking up a deadly habit more addictive than heroin? The answers can be found by examining the marketing practices of the tobacco industry, today's American culture, and most importantly, the role of parents.

Among US adults who have ever smoked daily, 82% tried their first cigarette before age 18, and 53% became daily smokers before 18. According to the recently released National Survey on Drug Use and Health, approximately 3,500 American youths aged 12-17 try their first cigarette each day. The good news is this is down about 20%, from 4,400 per day, in 2000, but the bad news is the number of girls smoking compared to boys is increasing. In 2004, 730,000 girls began smoking as compared to 565,000 boys.

The World Health Organization (WHO)/Centers for Disease Control and Prevention (CDC) Global Youth Tobacco Survey of 2000 found for the first time that female students in the US were smoking at the same rate as male students. In all other regions of the world, male youth continued to out-smoke females. The 2002 CDC Youth Tobacco Study found an 18% decrease in smoking from 2000 among 9th-12th graders, but the decrease among middle school students, grades six to eight, was not statistically significant. Smoking prevalence decreased just 0.2% for middle school girls while decreasing 1.5% among boys. Smoking tends to be more popular among white teen girls. The CDC found in 1999 that 40% of white high school females were current smokers compared to 32% of Latino and 19% of African-American high school females.

Tobacco companies deny marketing to youth, but a look at the numbers says otherwise. In order to maintain current market size and profits, tobacco manufacturers must recruit approximately 4,000 new smokers each day to replace the 1,100 smokers who die and the 3,000 smokers who quit.

The Global Youth Tobacco Survey Collaborating Group, in their report *Difference in Worldwide Tobacco Use by*

Gender, found that cigarette promotion and marketing influences adolescent smoking behavior to a far greater extent than adult behavior. A study of adolescent never-smokers also determined that tobacco marketing is a stronger influence in encouraging teens to smoke than exposure to peer, family smokers or demographic variables.

Big Tobacco is number two, just behind the automotive industry, for advertising expenditures in the US. Since 1997, tobacco marketing budgets have doubled, with over \$12 billion currently spent each year. Since tobacco advertising is not allowed on television, radio, or billboards, 80% of this \$12 billion yearly budget is spent on retail promotional marketing – at the 7-11s, Circle Ks, and AM PMs of America – where teens easily congregate and often find no carding required to purchase cigarettes. A study done in a town east of San Francisco found that compared to other stores in the same community, stores where adolescents shopped frequently had three times more marketing materials for Marlboro, Camel, and Newport, the three most popular brands smoked by American youth. Surveys of established adolescent smokers have found that retail stores are their primary source for tobacco. The other 20% of Big Tobacco's marketing budget is spent on event sponsorship and magazine advertising. In 2002, a California court found RJR Nabisco guilty of targeting youth through the selective placement of ads in magazines with high youth readership. Women's magazines' dependence on revenue from tobacco advertising has stifled coverage of the health consequences of smoking and has muted criticism of the tobacco industry.

Adolescents, still in the process of discovering who they are and who they aspire to be, learn much about the world and about smoking by watching celebrity behavior in the media. Actresses in movies tend to be beautiful, affluent and powerful, smoking in the context of romance, to appear tough, or to relieve stress - all situations adolescents might aspire to. One study that examined four decades of movies found the number of smoking scenes in 1990s movies to be at 1960s levels, before we knew the dangers of tobacco. Another study found that 89% of the top 200 movie rentals in 1996-1997 had scenes with tobacco. Fifth graders with high exposure to movie smoking had higher smoking rates than eighth graders with low exposure, even after controlling for sixteen other factors. Another study found

that adolescents in the highest quartile of exposure to movie smoking were 2.71 times more likely to initiate smoking than those in the lowest quartile. Children with parental restrictions on R-rated movies had substantially lower risk for smoking.

According to the 2001 Surgeon General's report on women and smoking, girls who start smoking are more likely to have parents or friends who smoke and have stronger attachments to peers than family. They also perceive smoking prevalence to be higher than it is, tend to be rebellious, have weaker commitments to school or religion, have less knowledge of the adverse consequences and addictiveness of smoking, and believe it can control weight and negative moods. They also tend to have positive images of smokers.

Adolescence is a difficult time, but more so for girls than boys. Girls become sensitive and their self-confidence goes down; they may struggle with insecurity and depression – cliques, boys, looks, and weight. Our culture does not have such rigid standards of looks and weight and being “the right way” for boys. Everyday, however, girls are bombarded with unrealistic images of “the ideal female” on magazine covers, television, and in the movies – our whole cult of celebrity. Partly because of hormonal changes, one in four adolescent girls suffers from depression, 50% higher than boys. Smoking becomes a way to mask this adolescent angst behind a protective wall of conformity, a solution to their anxieties. Girls preoccupied with their weight are more likely to take up smoking. Girls who diet daily are twice as likely as girls who diet less often to have tried smoking. And, compared with girls who report not dieting, those dieting more than twice a week have four times the odds of becoming smokers. Cigarette ads in women's magazines certainly sell the message that smoking helps with weight control – thin as rail models and even the name “Virginia Slims.”

For unknown reasons, girls seem to develop symptoms of nicotine addiction faster than boys, and women appear to be more susceptible to tobacco's carcinogenic effects. Dose-response odds ratios were 1.2 to 1.7-fold higher in women compared to men when looking at lung cancer susceptibility in one study. In 1987, lung cancer surpassed breast cancer as the leading cause of cancer death among women. In 1950, lung cancer accounted for only 3% of all female cancer deaths while in 2000 it was 25%. Current smoking is also associated with a higher risk for myocardial infarction in women compared to men, especially in women younger than 45.

Parents are the most powerful antidote to the tobacco marketing practices and cultural pressures placed on today's American teen girls. Parents who consistently disapprove of tobacco, are positively engaged in their

daughters' lives and have established rules and standards of behaviors have one-fourth the risk of their teens abusing substances than parents who are not as attuned to, and involved in, their daughter's lives. The National Center on Addiction and Substance Abuse (CASA) has consistently found that the more often teens have dinner with their parents, the less likely they are to smoke, drink or use drugs.

Just as Big Tobacco has their “Four As” for marketing cigarettes:

- Aspirational – making cigarettes desirable and fashionable
- Acceptable – making cigarettes socially and culturally acceptable
- Accessible – making cigarettes available and affordable
- Addictive – keeping smokers paying for cigarettes for long term

Parents have the “Four Ms” to raise healthy, tobacco-free daughters:

- Maximize time together to build a strong bond
- Model coping skills to manage stress and pressure
- Motivate their daughter's self-confidence by recognizing her strengths, skills, and interests
- Monitor their daughter's activities and behaviors with love and limits

Information on how to incorporate these four Ms into a healthy family life can be found at www.theantidrug.com, and additional facts on why girls are at increased risk for smoking and other risky behaviors at www.freevibe.com. If your daughter is already a smoker, the “five As” clinical approach to smoking cessation can help:

- Ask about her tobacco use
- Advise her to stop
- Assess her willingness to quit
- Assist her in formulating a quit plan
- Arrange for further advice and encouragement

The website www.whyquit.com contains a wealth of prevention and cessation resources.

Remember parents, as the television commercials state: “Parents. The Anti-Drug.” You are. Your parent power is your daughter's most valuable resource.

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Children in Hospitals

By John E. Monaco, MD

Newborns and Fever

When a child under the age of eight weeks develops a fever, pediatricians spring into action, invoking a protocol for treatment that has been tried and true for decades. There are a number of reasons fever in this age group is treated differently than in older kids for two reasons. One, there are certain perinatally transferred infections that can be devastating in this age group. These include type B Strep, enterococcus, herpes and others. Two, the immune system of babies in the newborns age group has not yet kicked into high gear, leaving them susceptible to overwhelming bacterial infections – infections they would be able to deal with much more effectively on their own later on in their childhood.

The typical story goes something like this: The parents of a one-month-old child call the pediatrician late one night because they notice the baby feels “warm.” They are advised to take the temperature and find that it registers 101.5° Fahrenheit. Upon hearing this, the pediatrician does not equivocate and directs the child and his or her parents to the emergency room immediately.

Once there, the baby will undergo a complete history and physical exam to determine the fever’s cause. For example, if everyone in the family has been suffering with colds, and the baby in question has been congested and coughing along with the fever, a viral respiratory infection could very likely be the cause. The doctor may also test the baby for RSV – particularly if it is the season for this ubiquitous respiratory virus – and perform other diagnostic tests like a chest X-ray and blood count.

By the same token, if the family has been suffering with a GI virus, with nausea, vomiting and diarrhea, and particularly if the baby is also having these symptoms along with fever, a GI work-up might be indicated.

The problem arises when there is no obvious source for the baby’s fever, even after a thorough history and physical examination. In this scenario, the doctor will likely initiate a so-called “sepsis work-up.” These tests can be traumatic for parents who see their baby as act-

ing normally except for a little fever and they wonder why their poor child must be subjected to such extreme measures, some of which are painful!

The work-up customarily consists of blood work, chest X-ray, blood culture, urine culture and examination and culture of the spinal fluid. In order to obtain spinal fluid, a lumbar puncture, or spinal tap, is necessary. This is usually the point of most significant emotional trauma for frightened parents who very often ask, “Why must our child endure a spinal tap for what may be a garden variety viral infection?” Their query is not without merit, as the vast majority of the time, babies who present with only fever are doing so because of a simple viral infection.

However, there are a few babies every once in a while who are actually diagnosed with meningitis, which can only be diagnosed via spinal tap. These children may present with fever with no other symptoms, and if antibiotics are not initiated immediately, can deteriorate rapidly. It is for these precious few, who can easily be saved by sepsis work-up and initiation of antibiotics, that the sepsis work-up for any baby under about six or eight weeks of age with unexplained fever is initiated.

Once the sepsis work-up is completed, the child must then be started on IV antibiotics and admitted to the hospital for observation and treatment, until the final cultures are read, which may take up to 48 to 72 hours. “Cultures” are simply plates of blood, urine and spinal fluid that are incubated in the lab in order to see if bacteria are present in these bodily fluids. The presence of bacteria in any of these fluids, in a sick baby with fever is one definition of “sepsis” – the condition we are trying so hard to prevent.

I always recommend to new parents to keep babies away from public places, strangers, and groups of other kids until their newborns are at least six or eight weeks old. This suggestion is partly to prevent the transmission of an infection that could be a major problem for a young newborn. But even more commonly, it is to prevent the appearance of fever, with no clear explanation, that will undoubtedly result in the trauma of an ER visit, multiple needle sticks and a two- or three-day

stay at the hospital, minimal. If the child DOES have infection in the blood, urine or spinal fluid, he or she may require hospitalization for ten days to even two weeks.

So, do whatever you can to protect your newborn from communicable infections that could cause fever. But if your baby does develop a fever in the first two months

of life, call your pediatrician immediately, and be prepared for this fever to be taken very seriously!

John E. Monaco, MD, is board certified in both Pediatrics and Pediatric Critical Care. His new book, Moondance to Eternity, is now available. He lives and works in Tampa, Florida. He welcomes your comments, suggestions, and thoughts on his observations.

Caffeine or No Caffeine: What's a Pregnant Woman to Do?

By Vikki Sloviter

Caffeine intake, among other habits, during pregnancy has been an ongoing debate among the medical community. Some obstetricians advise pregnant women to refrain from drinking anything with caffeine throughout the entire pregnancy, while others approve of occasional lattes. Some studies have found that indeed, too much caffeine can cause preterm labor or low birth weight babies. Other studies have found just the opposite: that drinking caffeine during pregnancy does not affect a baby's gestation. What is a pregnant woman to do? Which advice should she follow?

The most recent study says that moderation is key. In a Danish study published in the March/April 2007 issue of the *British Medical Journal*, Bodil Hammer Bech of the Institute of Public Health in Denmark and his colleagues found that reducing caffeine intake during the second half of pregnancy does not affect baby birth weight or gestation. In the double blind randomized trial, 1207 Danish pregnant women volunteered to help determine the effect, if any, of decreased caffeine intake on infant birth weight or length of gestation. The women were selected because they drank an average of three cups of caffeinated coffee per day in early pregnancy (before 20 weeks gestation) and were then assigned to receive either caffeinated or decaffeinated instant coffee, which they substituted for their regular coffee throughout the second half of their pregnancy. The women in both groups were not told how much or how often to drink their assigned coffee, and they were allowed to drink other caffeinated beverages if they wished. The women were interviewed at weeks 20, 25, 34 and four weeks after delivery to determine how much of the study coffee they were drinking, what other sources of caffeinated beverages they had, and if they smoked. At the final interview the women were also asked to guess which coffee they had been assigned to.

The results from 1153 of the participants were used for analysis and showed that the average baby's birth

weight for women who were assigned caffeinated instant coffee was 7.8 pounds whereas the average baby's birth weight for the decaffeinated group was 7.75 pounds. And, after adjusting for variables, the researchers found no statistical difference in gestational age (length of pregnancy) between the two groups; the weight difference was about half an ounce. The caffeinated group consumed an average of 182 mg of caffeine per day more than the decaffeinated group

Though decreased caffeine consumption did not seem to affect birth weight or gestational age, the number of cigarettes smoked during pregnancy did seem to affect birth weight. Approximately 25% of women in both study groups smoked one to ten cigarettes per day, and 13% of women in both groups smoked more than ten cigarettes per day while pregnant. The study supports previous research that has shown smoking during pregnancy can cause low birth weight. Among the women assigned to caffeinated instant coffee who smoked more than ten cigarettes per day at the study entry, the babies weighed an average of half a pound less than babies born to women assigned to decaffeinated coffee. Researchers were quick to point out, however, that caffeine consumption is associated with other lifestyle habits, such as smoking and drinking alcohol, so it is unclear which factor(s) may have affected the birth weight.

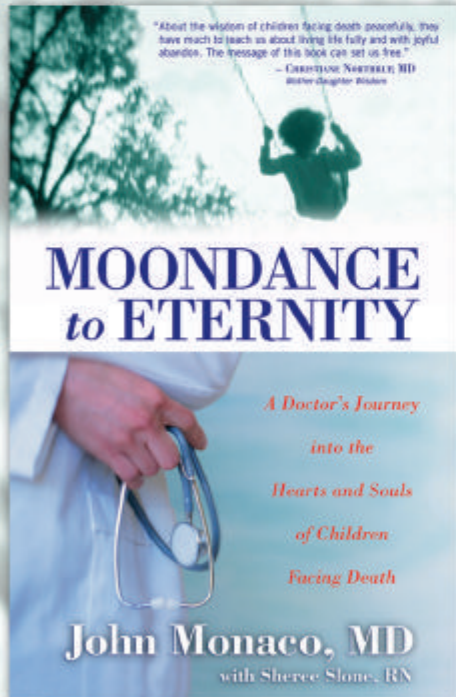
One of the limitations of the study was that the subjects were already coffee drinkers; they had already exposed the fetuses to caffeine in early pregnancy, so the effect of caffeine on birth weight is not entirely known.

So what is a pregnant woman to do? If she's been enjoying a caffeinated coffee every day, it probably won't affect the length of her pregnancy or the weight of her baby. But, if she has been smoking and drinking coffee, she might be putting her baby at risk for low birth weight. Pregnant women should consult their obstetricians for specific advice, but as with most things in life, everything in moderation.

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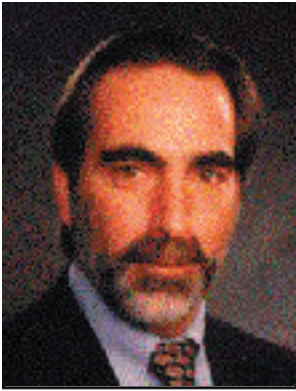
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Perspectives on Parenting

By Michael K. Meyerhoff, EdD

Average Age Versus Normal Range

A critically important concept about which mothers and fathers are routinely uniformed or misinformed is the difference between “average age” and “normal range” for major developmental milestones. Understanding and appreciating the significant difference may alleviate a lot of needless anxiety and lead to considerably healthier parental practices.

Let's take the onset of crawling, for example. If you observe 1,000 babies and note how old they are in months when they begin moving around, add all those months together and then divide the sum by 1,000 to get a quotient, what you end up with is the average age at which babies start crawling – about eight months. However, this is merely a statistic that has absolutely no meaning when it comes to monitoring a young child's developmental progress.

What you need to know is the normal range for this ability. That is the entire period during which the ability can appear and the child is still considered on course for healthy development. With respect to crawling, the normal range is roughly six months to ten months of age.

Now let's say one baby starts crawling at six-and-a-half months of age, and another baby doesn't start crawling until nine-and-a-half months of age. Which child is likely to begin walking first? Most people would assume that the child who started crawling at six-and-a-half months would walk first. After all, he is a month and a half ahead of the average, whereas the second child is a month and a half past the average. Clearly, the first child is “advanced” and the second child is “slow” when it comes to physical development.

But the fact of the matter is that the second child is just as likely to begin to walk first as the first. As long as both children are within the normal range, developmentally speaking they are completely equal and there is absolutely no predictive value in the difference within the normal range. Neither child is advanced nor slow. It is not even the case that one is early and the other is late. They are totally identical when it comes to assessing developmental progress.

Unfortunately, out of ignorance or for the sake of expediency, many books, magazine articles, and charts that appear in pediatric offices often focus exclusively on average ages. As a result, parents whose child is either ahead or behind the average age indicated for a given milestone are likely to get inaccurate and inappropriate ideas regarding how well their child is or is not doing developmentally.

The problem is exacerbated by the fact that we live in a highly competitive society and parents have a tendency to compare their child's progress to the progress of other children on a constant basis. Consequently, insignificant differences within normal ranges may produce judgments that can cause mothers and fathers some rather significant emotional distress.

Take the normal range for the onset of expressive language, that is, when children say their first words. The normal range for this ability is enormous, from six months all the way up to two years of age. Some children who are developing beautifully and who will eventually have superb language skills do start talking as early as six or seven months of age. But many other children who are developing beautifully and who will eventually have superb language skills don't say much of anything until they reach their second birthday. Therefore, as long as a child starts saying his first words within this period, he has to be considered developmentally equal to any other child who says his first words within this period, regardless of precisely when those first words are spoken.

But how often have you witnessed this scene? One set of parents intones to another set of parents, “Your Johnny is 18 months old and hasn't started talking yet? Our Janie has been talking since she was eight months old!” The unmistakable implication of this comment is, “Our Janie is a genius, and your Johnny must be slow!” And if you are Johnny's mother or father, once that notion gets into your head, it is virtually impossible not to take it to heart. It sure would be nice to know that any such ideas of inferiority are based on erroneous assumptions and are entirely unwarranted.

It also is unwise to get a sense of superiority. Let's say Janie does start talking long before all the other little children in the neighborhood. On the other hand, she doesn't start walking until all the other kids have been toddling around for a few months. Nevertheless, everyone is well within the normal range for both abilities. However, her parents subsequently say something like, "Well, Janie is very sociable but she's not very physical." Years down the road, Janie grows up to be a non-athletic blabbermouth. Was that her developmental destiny, or was she channeled into certain behavior patterns because her mother and father established expectations based on erroneous assumptions and shaped their parental practices accordingly?

By the way, focusing on average ages can be extraordinarily dangerous when it comes to safety considerations. Going back to crawling, if parents look at the average age of eight months for the onset of this ability, they may assume they can put off childproofing their house for another few months. And regrettably, they may learn about normal ranges from the staff at the hospital emergency room if their child begins moving about well within that period but well before the average age.

Therefore, parents would be well advised to seek out books, articles, and charts that feature normal ranges

instead of average ages. They also should know that just because a child goes beyond a normal range every now and then, that does not necessarily mean the child is in serious trouble. Of course, the more a child goes beyond the normal range or even the more often he seems to be approaching the upper end of the ranges for different abilities, the more parents should start to be concerned and should seek some professional advice.

But the bottom line is that rates and patterns of development during the early years are highly variable, and not all children who are doing well are doing the same thing at the same time. While it is extremely tempting – and even natural to a certain extent – to start applying adjectives like "early" and "late" or "advanced" and "slow" or "ahead" and "behind" when comparing one child's progress to that of other children, it is important for mothers and fathers to keep in mind that most differences detected during informal comparison sessions are totally meaningless and that giving them any sort of significance may have consequences that are both distressing and detrimental.

Michael K. Meyerhoff, EdD, is executive director of The Epicenter Inc., "The Education for Parenthood Information Center," a family advisory and advocacy agency located in Lindenhurst, Illinois. He may be contacted via e-mail at epicentrinc@aol.com.

Toys With Small Magnets Too Dangerous

In the past year the Consumer Products Safety Commission (CPSC) has issued five toy recalls that included more than eight million units that contained small magnets that could fall out and pose a serious health hazard to children. In the United States, at least 33 children experienced life-threatening intestinal injuries when they swallowed more than one magnet that had fallen out of a magnetic toy. One of these injuries was fatal.

Even though CPSC issued a statement in 2006 that warned parents of the danger of loose magnets, parents are still buying these toys and children are still swallowing magnets. The CPSC's Safety Alert provides the following advice regarding ingested magnets to parents:

- Seek immediate medical attention if you think your child has swallowed a magnet.
- Look for non-specific abdominal symptoms (nausea, abdominal pain, diarrhea, vomiting, etc.).

- Keep small magnets – and toys that contain small magnets – away from children that could swallow them.
- Inspect toys that contain small magnets and look for missing or loose pieces that could indicate that a magnet could have come out.

Even though most toys with small magnets are designed for children over age six, several of the children who had swallowed the magnets were between ages six and eleven; children of all ages can swallow magnets and are at risk of intestinal injuries.

New voluntary standards for toys with magnets were approved in March 2007, but until these types of toys no longer pose a hazard, we strongly suggest that parents not purchase them at all.

(The *Pediatrics for Parents* website, www.pedsfor-parents.com, has information on the latest product recalls.)

Toxins in Playgrounds

By Christine Orchanian Adler

If you've been feeling guilty that you can't bring the kids to the park as much as they'd like, take heart. You may have reduced their risk of getting cancer. That's because for decades, almost all wooden playground equipment has been made from pressure-treated wood containing chromated copper arsenate, or CCA, a pesticide that contains arsenic. While the treatment helps the wood stand up to termites, humidity and beetles, the arsenic in it can leach out for years, posing a health hazard to children who can get arsenic residue on their hands, and then put their hands in their mouths.

The popular lumber is used for most playground equipment, as well as decks and picnic tables, because the treatment prevents rot. But the nation's top product safety official said that children could face an increased lifetime risk of developing lung or bladder cancer from using playground equipment made of wood treated with arsenic. There is also strong evidence that arsenic from CCA-treated wood can leach into the soil around it for years, though the amount and rate at which this happens varies considerably depending such factors such as local climate, acidity of rain and soil, and how much CCA was applied. It is for these reasons that CCA-treated lumber phased out of production at the end of 2003. But because the amount of arsenic drops significantly as the wood ages, the Environmental Protection Agency (EPA) will not advise homeowners to remove existing decks or other constructs that are made with the wood.

The dangers of CCA is not news to environmental experts. Since the 1970s, environmental groups have been urging a ban on CCA. Although the EPA did ban most arsenic pesticides years ago, it made an exception for pressure-treated wood. But the manufacturers didn't agree to start phasing out the production of the lumber for residential use for another two years. Representatives of the wood-treatment industry insisted that CCA-treated wood was safe if dried and used properly, but they admitted that because of competition, most plants did not make sure the wood was dry before shipping it.

Because there is some uncertainty about the amount of arsenic exposure that is necessary to cause cancer, the staff of the Consumer Product Safety Commission (CPSC) and the EPA staff worked together to calculate the additional probability that an individual will develop lung or bladder cancer during his or her lifetime

because of exposure to arsenic from CCA-treated wood playgrounds. Not every exposed individual will get cancer during his/her life, and the staff used a range of values in their calculations. They estimate that the increased lifetime risk of developing cancer from exposure to arsenic from playing on CCA-treated wood playgrounds during early childhood ranges from about two in a million to 100 in a million. However, they also note that this risk depends upon a number of factors, including:

- The number of days the children play on the CCA-treated playground each year
- The number of years they play on the CCA-treated playground
- The amount of arsenic picked up on their hands while they play
- The amount of arsenic they ingest from their hands throughout the day

For those who already have structures on their property made of the treated wood, the EPA offers the following safety tips:

- **Sealants** Using paint or stain on a deck or play equipment can stop some of the leaching and immobilize many of the loose particles. Oil-based stains should be used because they penetrate the wood and don't require sanding or scraping, which would stir up the arsenic. Urethane-type sealant should be re-applied every one to two years. Note: water-based sealants did not seem to help.
- **Covers** Put tablecloths over picnic tables. Do not serve or cut food directly on the wood.
- **Avoid Bleach** Bleach and other oxidizing cleaners will release arsenic, and convert the chromium in CCA into a more toxic chemical, hexavalent chromium, which was the topic of the movie "Erin Brockovich."
- **Wash Hands** Thoroughly washing hands with soap and water immediately after touching the treated wood will help remove chemical residue.
- **Clean Shoes** Keep a towel by the door for children to wipe their feet on after they have played on the equipment or walked on the deck.

- **Store Toys Elsewhere** Don't store children's toys under decks, and don't allow children or animals to play there.
- **Don't Burn, Saw or Sand the Wood** All of these actions will release toxic chemicals or sawdust. If you must sand or saw the wood, wear gloves and a dust mask, dispose of all sawdust and debris, and avoid bringing air-borne sawdust indoors. After working with the wood, and before eating, drinking, toileting or using tobacco products, wash exposed areas of the body thoroughly.
- **Wash Clothes** Because preservatives or sawdust accumulate on clothes, they should be washed before reuse. Wash separately from other household clothing.
- **Turn the Soil** Till the soil near play equipment and decks, and cover it with topsoil or virgin mulch (which has no CCA-treated wood in it). Because arsenic stays close to the soil's surface, this will reduce the risk.

In addition, the Environmental Working Group has teamed up with an independent lab to offer the public

arsenic testing kits, at cost, through its website, www.ewg.org.

Keep in mind, however, that the ban on CCA-treated wood merely focused on removing the threat of arsenic. All pressure-treated wood contains chemicals, which are necessary for preserving the lumber for long periods of outdoor use.

"I don't want the public misled to think that this ban automatically created something good," says David Engert, owner of The Great Outdoor Toy Company. "Any wood that is intended for outdoor use will need to be treated, and will therefore need to contain chemicals. And all chemicals carry risks." Redwood and cedar do not pose a threat, as they do not require pesticides.

Christine Orchanian Adler is a writer and editor whose work has appeared in various publications throughout the Northeast region. She earned her master's degree in creative writing from Manhattanville College, and is editorial consultant of the literary journal, Inkwell. Her work includes articles relating to health and family issues, as well as book reviews and poetry.

Weight-Loss Tips

By Roy Benaroch, MD

Many children and their parents struggle with concerns about becoming overweight, and it's easy to become overwhelmed with advice about diet and exercise. Too much information about exact portion sizes, calorie counts, and rigorous exercise routines can discourage parents before they've even started! Fortunately, some very simple advice can go a long way towards ensuring your whole family reaches a healthy weight that can be maintained.

- Turn off the TV. The more television watched, the more weight children will gain. You don't have to fight to get kids to exercise — but you do need to get them away from the television set.
- Eat slowly. When kids down their meals too quickly, they don't reach a point where they feel "full." Fast eating means overeating. Use mealtimes for conversation and relaxation, not just for shoveling down food.
- Drink water rather than high-calorie juice and soft drinks with meals. Sugary drinks add plenty of calories, and don't help you feel full.

- Eat as a family. When kids eat with parents, they choose healthier foods and more reasonable portions. This also gives more opportunity for conversation and modeling table manners.
- Save treats for special occasions. Dessert will be enjoyed more if it's a treat, rather than something expected after every dinner.
- Offer low-calorie snacks before, during, and between meals. Carrot sticks and celery nibbled right before a meal can really cut down an appetite.
- Try food that looks like food. That is, food that's closer to "natural" is more wholesome and better than processed foods, and less likely to lead to excessive weight gain. Think about the difference between a fresh apple, applesauce (with its added sugar and stabilizers), and apple pie (loaded with sugar and extra fats).

Incorporating just a few of these suggestions can help your entire family reach healthy weight goals. You can do it if you try!

Lead, Lead, Everywhere, What's Can Parents Do?

By Vikki Sloviter

With the seemingly endless number of recalls concerning lead in children's toys, parents may be at wit's end trying to determine their children's risks for lead poisoning. Here's a quick run down on lead, how it may affect your children, and what you can do to minimize your child's risk.

What is Lead and Why are Toys Made with It?

Lead is a naturally occurring heavy metal that is found in the earth's crust, but is more commonly found with other elements, including zinc, silver and copper. Its periodic symbol is Pb, for the Latin *plumbum* ("soft metals"). Lead is abundant and cheap, and has chemical qualities that make it versatile and easy to work with. Believe it or not, lead acetate was once used to sweeten wine. These days, lead is used, among other applications, in building construction, paint, batteries, ceramic glazes and bullets. Its qualities have made it a leading building material, and up until 1978, most houses in the U.S. were painted with lead paint.

Many parents ask why toys – objects that manufacturers know children might put in their mouths – would ever be made with something that we know is dangerous, even life threatening. The answer is complicated, but basically lead is, according to Slate's Christopher Beam, "bright, durable, flexible, fast-drying and cheap." Not only that, but lead is mildew resistant and anti-corrosive. Unfortunately, lead is also toxic.

How Lead Affects the Body

Both adults and children can suffer from lead poisoning, but children are at an increased risk because they – especially children those under age six – can absorb lead into their bloodstream at a greater concentration than older children and adults, and their brains and central nervous systems are still developing.

Lead poisoning is often difficult to detect, especially at lower levels. But, even low levels of exposure can result in reduced IQ, learning disability, attention deficit, slowed growth and hearing impairment. Increased levels of exposure can lead to kidney damage, mental retardation, coma and death. According to the National SAFEKIDS Campaign fact sheet, it was estimated that in 2004 890,000 children ages one to five had high enough lead levels in their blood to affect their intelligence, growth and development, though more conservative estimates indicate that about 300,000 U.S.

children have high blood lead levels.

What's Been Done to Safeguard our Children?

Over the decades, the Centers for Disease Control and Prevention (CDC) has reduced the acceptable blood lead level, from 60 micrograms per deciliter ($\mu\text{g}/\text{dL}$) before 1970 to 30 $\mu\text{g}/\text{dL}$ in 1985, to 25 $\mu\text{g}/\text{dL}$ in 1991 to 10 $\mu\text{g}/\text{dL}$ today. Even though a blood lead level of 10 $\mu\text{g}/\text{dL}$ is considered safe, a 2003 study lead by Richard Canfield, PhD at Cornell University found that some children experienced intellectual impairment at even lower levels of concentration, and there are medical experts who believe the threshold should be lowered yet again, to five $\mu\text{g}/\text{dL}$.

The Consumer Products Safety Commission limits the lead concentration in paints used on products that are accessible to children, including furniture, to 0.06% (or 600 parts per million). This ban is designed to protect children from lead exposure and poisoning because children characteristically put their fingers and other objects in their mouths that could otherwise contain hazardous levels of lead.

What Parents Can Do?

Lead poisoning is rarely an acute event, where a child ingests a huge amount of lead and becomes instantly sick. Rather, lead poisoning can take weeks or months to become noticeable, and even then parents may not know what is wrong with their child. Children who are most at risk of lead poisoning are those who have regular, long-term exposure to lead. Namely, these children probably nibble on lead-based paint chips that have flaked off of walls in older home, inhale household dust that may contain lead paint particles, play in lead-tainted soil, or regularly mouth toys that are painted with lead paint.

If your child has played with a lead paint recalled toy, take the toy away from the child. Then think about how often your child may have put the toy in his mouth. If the toy was constantly in his mouth over a period of weeks or months, then you should ask your child's doctor if he should be tested for lead. If your child only held the toy in his hands and rarely if ever put it in his mouth, then you probably don't need to have your child tested, but it doesn't hurt to ask the doctor if you're concerned anyway. It costs about \$15-\$20 to have your child tested for lead in his doctor's office.

The Bottom Line

Most parents – especially those that live in housing built after 1978 – should probably worry more about choking and magnetic toy hazards than the lead-in-toys recalls. Children in these homes are at more risk of choking on a small toy or food than on having an increased lead level. However, some medical experts believe that all children should be tested for lead at 12 months and 24 months of age.

Since children who live in older homes built before 1978 are at a considerably increased risk of lead exposure, they should be tested for lead at 12 and 24 months of age, and then every six months afterwards. Older homes should certainly be tested for lead, and sources of lead paint (doors, walls, etc.) should be repainted, sealed, and/or replaced to prevent further lead exposure.

Cough Medicine Dangers

By Vikki Sloviter

If your infant or toddler has ever had a cough and/or cold, you've probably gone to your local drugstore to find something to help alleviate the symptoms. You headed for the aisle of cough and cold medicines and hoped you could find something to relieve her stuffy nose and cough. You spotted Children's Tylenol, but you couldn't use it because your child is under age six. Then you saw Infant Tylenol, which looked like it might do the trick. But then you read the carton carefully and realized it's for children over age two. But your child is under age two. What are you supposed to do?

On January 12, 2007, the Centers for Disease Control and Prevention (CDC) and the National Association of Medical Examiners (NAME) released a report of a study where they investigated infant deaths due to cough and cold medicines. In 2004-2005, more than 1,500 children under age two were treated in U.S. emergency rooms for problems caused by cough and cold medications, and in 2005 three infants ages one month, three months and six months died as a result of being given too much cough and cold medicine. In all three cases, the infants had abnormally high levels of pseudoephedrine, a nasal decongestant, in their blood samples. The pseudoephedrine concentrations of the three infants who died ranged from 4,743 ng/mL-7,100 ng/mL, more than ten times the recommended amount for children ages 2-12 (180 ng/mL-500 ng/mL). The six-month-old infant had been given prescription and over-the-counter cough/cold medications, both of which contained pseudoephedrine. And, two of the infants also had detectable levels of dextromethorphan, a cough suppressant, and acetaminophen in their blood samples. None of the children had a heart condition that might have attributed to their premature deaths, though two of the children were found to have had respiratory infection.

Since 1997, the American Academy of Pediatrics (AAP) has advised parents about the dangers of administering cough and cold medicines to infants, citing that

cough suppressants aren't very effective in suppressing coughs, that there can be serious side effects in children so young, and parents could unintentionally give too much medicine. The AAP's recommendations are based on studies in children age two and younger that determined that cough and cold medicines are not much more effective than placebo in reducing cough and other upper respiratory infection symptoms in children under age two.

More recently, the FDA passed the Combat Methamphetamine Epidemic Act that bans over-the-counter sales of cold medicines that contain pseudoephedrine because that ingredient can be used to make methamphetamine. Consequently, many cough and cold medicines are now made with other nasal decongestants. However, many public health officials and doctors suggest that using a rubber suction bulb (with nasal saline to loosen mucus if necessary) or cool-mist humidifier is the best method to treat nasal congestion in children under age two.

Due to the dearth of information on the safety or toxicity of using cold and cough medicines in children under age two, the FDA does not provide a dosing regimen for that age group, which is why you can't find an over-the-counter cough and cold remedy designed for such young children. Instead, the FDA tells consumers to "consult a doctor" for safe dosing recommendations. Parents of infants should not take dosing into their own hands. Don't use a child's or adult's dosing recommendation to try to approximate a safe dose for an under-two child. Call your child's doctor who knows your child's medical history and any conditions she may have that could contraindicate the use of over-the-counter medications.

Vikki Sloviter received her BA in History of Science and Medicine from Yale University. She lives in Bucks County, Pennsylvania with her husband and three young children. She also proofreads, copy edits, researches and writes for Pediatrics for Parents and NeedyMeds.com.

Your Questions Answered

Drs. Alvin Eden, Roy Benaroch and Michael Meyehoff answer your questions. Dr. Eden practices in Forest Hills, NY. Dr. Benaroch's practice is in Atlanta, GA. Dr. Meyerhoff is the executive director of the Epicenter, Inc. in Lindenhurst, IL.

Send your questions to QandA@pedsforparents.com or Pediatrics for Parents, PO Box 219 Gloucester, MA 01931. Please keep them general in nature as we can't give specific advice nor suggest treatment for your child. All such

How Much Milk?

Q I have an 18-month boy. I have heard that he needs to drink a quart of milk each day to stay healthy. Is this true?

A No. Although this belief is great for the dairy industry, there is no medical or nutritional reason for your child to drink that much milk. As a matter of fact, the opposite is true. There are important reasons not to allow your toddler to drink a quart or more of milk a day. All of us, besides your toddler, are much better off drinking considerably less milk. Two cups of milk per day (a total of 16 ounces) are enough to satisfy all your child's nutritional needs, including his calcium requirements. The total daily calcium recommended for 1-3 year olds is 500 mgs. One cup of milk contains 250 mgs. of calcium, as does one cup of yogurt. If your toddler refuses to drink milk, yogurt and cheese should be offered each day. Parents often describe their toddlers as being picky and finicky eaters. One of the important causes is that so many children drink enormous quantities of milk (and of juice as well), leaving very little room for any solid food.

While on the subject of milk, the current recommendation of the committee on Nutrition of the American Academy of Pediatrics is to avoid the use of low-fat of skim milk until the child is two years old and I agree. Studies have shown that the brain needs a certain amount of fat for optimal development during this period of rapid growth.

Alvin Eden, MD

Pink Eye

Q What should I do about a painful or pink eye?

A Irritated, painful, and runny pink eyes can quickly spread through a school or home. Though usually caused by infections, there are a few other triggers of pink eye that parents should also think about.

If your child has a pink eye following a mild injury, there may be a scratch on the surface of the eye. If the child reports a feeling that there's something in the eye,

or if sand or other small debris caused the scratch, try to flush the eye out with water or a contact lens soaking solution. A soaking solution or contact lens saline will be more comfortable to use as a flush solution than tap water, but never use a contact lens cleaning solution directly in the eye. Your child will be more comfortable if you keep the room dark or offer a pair of sunglasses. If you can't flush out the debris, or if your child continues to complain, see your pediatrician.

Following a more serious injury, such as an eye hit by a hit baseball or poked hard with a stick, don't try to flush the eye yourself. Cover the area with a cup for protection, and contact your child's doctor, optometrist, or ophthalmologist for instructions.

Most common pink eyes occur without any injury, and are triggered by infection. Often, the eye is gooey and red. You can help your child feel more comfortable with a cool wet compress or artificial tears. Contact your child's doctor to help determine if a prescription drop is necessary. Though viruses that won't improve with eye drops cause some cases of "pink eye," bacterial pink eyes will improve faster with antibiotic treatment. Both bacterial and viral pink eyes are very contagious, so try to keep hands clean and avoid sharing towels and linens. Viral pink eyes remain contagious even when they're treated with prescription drops.

Eyes can also become pink and irritated from allergies. Usually, the child will complain of an itchy feeling, and the eyes will be watery rather than gooey. Over-the-counter drops such as Zaditor offer good relief for allergy-related pink eyes.

Roy Benaroch, MD

Daycare Dilemma

Q I'm torn whether or not to put my children in a daycare or leave them with our expensive nanny. My sister-in-law thinks that a day care situation for her child is the perfect situation for him to "absorb his environment;" he's apparently like a sponge. I just can't see that being the case in a daycare situation. The nanny is engaging and is good to the children. She does have a bit of a temper from time to time but I put myself in her place and know that I myself have

a bad day and might get upset at the kids, and they're my kids. Why would I expect anything different from a nanny? It's a tough job that pays \$12.50/hour for two toddlers. My question: is it better to leave my children with a nanny or move them to a daycare center?

A There is only one answer to any question like this, and that is, "It depends on the child." While a daycare experience should not be considered "necessary," that doesn't mean it can't be "nice." If the facility is well designed and staffed, a toddler can be exposed to fun and interesting experiences that otherwise might not be available to him. What he would be missing is the greater amount of one-on-one attention given to him in a nanny situation. While that kind of attention is nice, if the child is reasonably independent and only seeks occasional adult "consultations," it need not be considered necessary.

So my suggestion would be to find a good daycare facility. The staff should allow you to conduct a "trial run." Let the toddler spend an hour or two in the situation, and if he seems to be excited about the other kids, the activities, and the materials available to him, if he seems comfortable with the personnel, and if he seems to be enjoying himself, then it would make sense to consider enrolling him. If not, stick with the current situation. It doesn't appear to be broken, so don't feel compelled to fix it.

Michael K. Meyerhoff, EdD

How Much Water?

Q My two-month-old baby girl refuses to drink any water. Should I worry about it?

A No, there is no reason to worry. It is true that babies do require water, but they get all the water they need from breastmilk or infant formula. If your daughter is drinking an adequate amount of breastmilk or formula, it is not necessary to force her to drink any water. I would also advise you not to add sugar to the water because a baby who gets accustomed to the taste of sugar water will certainly refuse to drink plain water.

While on the subject of water, let me remind our readers that breastfed babies should not be offered any water until they are at least two months old, according to the current recommendations of the Academy of Pediatrics.

I would suggest that you continue to offer your baby water between feedings, especially on hot days. Sooner or later she will start to drink water, especially if she really is thirsty.

There is a final point I would like to make about water as it relates to fluoride. In order to help prevent tooth decay, all children require daily intakes of fluoride, starting at six months of age. If you live in a community where the water supply contains fluoride and your child drinks tap water, no additional fluoride is required. If your water supply is not fluoridated or if your baby only drinks bottled water or no water at all, she will require supplemental fluoride. Discuss this with your baby's doctor.

Alvin Eden, MD

Sleeping on Back

Q I have been told that it's important that my new baby boy sleeps on his back. I'm worried that he may choke while he's asleep. Please tell me what to do.

A The current recommendations of the American Academy of Pediatrics as well as every other reputable organization are to make certain that all babies be put to bed sleeping on their backs for at least the first six months of life. Ninety-five percent of Sudden Infant Death Syndrome (SIDS) cases occur by six months of age, and since the "back to sleep" campaign we have seen a drastic decrease in the number of babies dying from SIDS.

Sudden Infant Death Syndrome remains a great tragedy and we still do not know the cause. But we do know that a baby that sleeps on his back will be at much less risk. There is absolutely no question that putting your baby boy on his back will go a long way in preventing SIDS.

One further point related to SIDS. If you and your baby sleep in the same bed (co-sleeping), don't smoke. Studies have shown that parental smoking increases the risk of SIDS. As a matter of fact, exposure to smoke increases the risk of SIDS for babies who sleep in their own cribs.

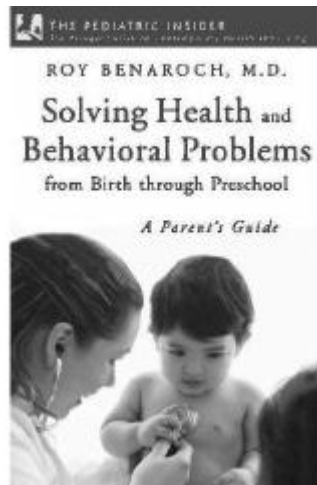
Alvin Eden, MD

Our Podcast

Have you listened to our podcast? If not you are missing great interviews with our writers. In podcast 36 Betsy Miller talked about congenital hip dysplasia. In the latest podcast Dr. John Monaco, a regular contributor, discusses his new book, *Moondance to Eternity*. Drs. Alvin Eden and Roy Benaroch answer questions and Vikki Sloviter presents information on recent recalls.

The podcasts are available on iTunes or from the *Pediatrics for Parents* website.

JUST RELEASED!



As parents, we've all faced the frustration of not knowing what to do when a child is sick, or not knowing the best way to handle a behavioral problem. Do you need to rush to the doctor or offer over-the-counter remedies? Which ones? What problems are likely to improve on their own, with gentle reassurance only? This book covers what parents need to know, with tips and information shared by a true Pediatric Insider. Not only are common medical complaints reviewed, but also frustrating challenges in behavior and discipline. What's the best way to teach a preschooler to behave? Special topics covered also include the prevention and treatment of common infections, and how to communicate with your young child in a way that helps parents learn what's really wrong while helping the child begin to feel better—without relying on the medicine cabinet.

Chapters Include

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Ear Infections	Pink Eye
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Roy Benaroch, MD, FAAP, is a father of three and a board-certified pediatrician practicing near Atlanta, Georgia. He is an Assistant Clinical Professor of Pediatrics at Emory University, and a frequent contributor to *Pediatrics for Parents* and other publications.



Also available from Dr. Benaroch is *A Guide to Getting the Best Health Care for Your Child*. Released in January 2007, this unique book also shares the perspective of revealing information that ordinarily is kept secret by the insiders of the pediatric profession. Topics covered include how to choose a pediatrician; working with specialists; how to get the most out of encounters in the office, ER, and hospitals; using medicine safely; getting reliable health information from the media; when and how to get your pediatrician on the phone; choosing and using health insurance; how to save money even if you don't have insurance; and preventing medical errors.



Should Babies and Toddlers Watch Television?

By Elizabeth Pantley

So much television programming is aimed at young children. Much of it appears to be educational: teaching the ABCs and life skills. When

is it appropriate to introduce a baby to television, and what do parents need to know about this topic?

A great deal of research has been done on the effects of television on children's lives. The first step in making the decision is to get the facts. Because nearly all of us have one or more TV sets in our home, and since most of us watch some TV nearly every day, we may not want to hear what research tells us, but these are things parents need to know.

- Experts suspect that babies younger than two years old view TV as a confusing array of colors, images, and noises. They don't understand much of the content. Since the average TV scene lasts five to eight seconds, your baby or toddler doesn't have enough time to digest what's happening.
- Cartoons and many children's shows are filled with images of violence. If you find this hard to believe, surf the TV on Saturday morning. The realism portrayed in today's cartoons has moved light years beyond the Bugs Bunny type of violence. Many children's shows are animated versions of adult action films. Research shows that exposure to this type of programming increases the risk of aggressive behavior and desensitizes children to violence.
- Babies and toddlers have a very literal view of the world. They can't yet tell the difference between real and pretend, and they interpret what they see on TV as true life. Research has demonstrated that many young children believe that TV characters actually live inside the TV set. This can confuse young children's understanding of the world and get in the way of their learning what's right or wrong. It can paint a picture of a frightening, unstable, and bewildering world and your little one does not yet have the faculties to put what he sees into proper perspective.
- Television watching can be addictive. The more that children watch, the more they want to watch.

Even toddlers can become drawn to the set. Once addicted, turning off the TV can become a daily battle. Children who watch TV excessively often become passive and lose their natural creativity; they eventually have a hard time keeping themselves busy, and they lose valuable time that should be dedicated to "play" the foundation of a healthy childhood and the primary way that very young children learn.

- Parents sometimes unwittingly begin to use TV more and more as a way to keep their children happy and quiet. It takes a strong will and dedication to avoid the easy route provided by this free and easy yet sometimes dangerous babysitter.
- Children experience unparalleled physical, mental, and emotional growth in the early years of life. Time spent watching television is time taken away from more healthful activities that nurture growth and development.
- Children who watch a lot of television during their early years are at risk for childhood obesity, poor social development, and aggressive behavior. They often have trouble adjusting to preschool or kindergarten. According to a study by Yale Family Television Research, children who watched excessive television as less cooperative, less imaginative, less enthusiastic about learning, and less happy than those who watched little or no TV.

You may have noticed that all of these points demonstrate the negative aspects of letting babies and toddlers watch TV, and you're wondering if there are any positives. There are a few, but I'll be honest: I had to be very creative to come up with this list, since published research doesn't demonstrate many good points for putting a young child in front of a television. But we need to be realistic and acknowledge that most of us aren't going to put our TVs in the closet until all of our children start school. Here are some of the good points of television for children:

- Quality children's programming can teach your child basic academic skills, such as the ABCs, counting, addition, science fundamentals, basic language skills, manners, and even early reading skills.

- Your child can view things she might not otherwise see in daily life: exotic animals, distant lands, musical instruments, historical places, and diverse lifestyles. Your child can learn about the world beyond her home and neighborhood.
- Your child can learn basic social skills from watching wholesome programming: how to play with other children, how to use good manners.
- Using extraordinarily careful selection and restraint, a little bit of television can provide a parent with much-needed down time, or time to catch up on tasks that need adult-only attention.

Here are some tips that may help you minimize the negative and maximize the positive effects of television watching for your little one:

- Hold off introducing television even videos to your baby as long as possible. If you wait until your child's second birthday, you can consider yourself incredibly successful in starting your little one off well and with the kind of real-life interaction that is so important for his development. If you decide to allow TV before your child turns two, choose programming carefully, limit viewing time and skip days when possible. The less time, the better! Set a goal, such as no more than 30 minutes or an hour per day, or one favorite show, so that you'll not be tempted to turn the TV on too frequently.
- Watch programs yourself before you allow your baby or toddler to watch them. Just because a network markets a show to young children doesn't mean it will reflect your own family's morals and values. You will be amazed to discover that many programs aimed at children contain violence or topics that are inappropriate for your child. Don't assume that your baby can pick out the moral message from a program that features violence or

conflict on the way to an important lesson.

- Pay attention also to commercials surprisingly, an excellent children's show will sometimes feature commercials that depict the exact things you don't want your little one to see!
- Choose programs that are developmentally appropriate for your child. For you, this means slow, boring, and probably somewhat goofy. But choose from your child's perspective, not your own.
- Invest in a collection of appropriate and educational videos for your child so that you won't be confined to network programming schedules when you are ready to let your little one watch something.
- Watch along with your child when you can so that you can monitor your child's reactions to what he's seeing. Invite questions and discuss what you are watching so that you can understand your little one's take. Point things out and talk about what is being taught to get the most out of educational TV. You may even follow up with some lessons afterwards.
- Avoid keeping the TV on when no one is actively watching. Many people do this and are used to the background noise the set generates, but your child will almost surely be exposed to programming that is inappropriate for her.
- Make a conscious decision about how you will use television in your family; don't watch it by accident or default.

Elizabeth Pantley is a parent educator and the author of many parenting books. This article is a copyrighted excerpt from Gentle Baby Care by Elizabeth Pantley. (McGraw-Hill, 2003). Elizabeth contributes a Parenting Pointer to the Pediatrics for Parents podcast.



When Your Child Won't Nap

By Cynthia MacGregor

At some point, your child is going to outgrow napping... perhaps when he or she is around four years old. But it's likely that, at a much younger age, he'll go through

a period of resisting naps, even though you know darned well he still needs them. This may be a transitory phase, or it may be an intermittently recurring pattern. But in either case, you'll find yourself telling him it's naptime only to be met with "No!" or "I don't want to" or "I'm not tired."

This is not the "No" of a child who's learned the power of that word and is saying it as often as possible. Something else is at work here. And it's not fear of the dark and the closet monster. It's broad daylight. Neither is it likely to be fear of bad dreams. Few kids have bad dreams during naps. Then what is this nap opposition all about?

There are several common reasons for nap resistance, so your first step is to decide whether one (or more than one) of these is the operative here, and then take proper steps to counteract it.

Big Kids Don't Nap

Some kids refuse naps out of wanting to be like the child's big sister, or the girl next door, or some other "big kid." Big kids don't take naps. Naps are for babies... at least in her mind. So she yearns to get naps expunged from her daily schedule, believing that this will signal that she's growing up.

You can try reasoning with her, telling her that you still nap sometimes (if this is true), or that her other parent does (or Nana, or Uncle Jeff). Naps aren't only for little kids. This likely won't win her over, but it will make a small dent in her mental armor against napping, even if at first she seems adamant as ever.

After that, firmness is called for: "If you don't nap, I won't take you to the playground this afternoon." "If you don't go into your room and lie down right now, there's no dessert for you tonight."

Concern About Missing Something

The motivation for many kids to resist naps is the concern that they'll miss something while they're sleeping.

Infants, who are not as aware of the world around them, don't have this conflict regarding sleeping. But as kids grow and become more conscious of what's going on in their ever-enlarging worlds, they become aware that interesting things might happen while they're asleep.

It might be a specific concern: "If I fall asleep, I might miss the ice cream truck." (This despite the fact that the ice cream truck doesn't come around till 4:00, and you're putting the child in to nap at 1:00.) "If I fall asleep, I might miss Barney on TV." It might be a general concern: "What's going to happen while I'm sleeping that I won't know about?" Will he miss seeing a fire truck screeching past the house? Will someone interesting ring the doorbell? Maybe Nana will come over to visit, or that nice neighbor from down the block. Maybe one of Mom's friends who had a child will come over to visit, bringing her child to play with him and he'll miss out because he's sleeping.

The answer is understanding, mixed – once again – with firmness. While you can't promise him that Nana won't come to visit, and you don't even want to raise that issue aloud unless he specifically verbalizes it first, you can explain that he never naps for more than one hour, and the ice cream truck won't be around for three hours. And Barney isn't on at this time either.

Then you have to be firm and insist that he go lie down... adding, if necessary, that if he fails to comply, he'll lose privileges.

Don't Stop The Carnival

Sometimes the issue isn't that the child is afraid of missing something (something specific or just a generalized "something") that might happen while he's napping, but rather the issue is that he's having too much fun now and doesn't want to stop. Your best defense here is to plan ahead for naptime.

Just as you wouldn't fill your child up with sugary sweets, let him take part in a boisterous, energizing game, or do anything else that would "rev him up" just before bedtime, you can count down to nap time similarly. See to it that his pre-nap activity is something relatively quiet and also is not something that's going to be too much fun to take him away from. Just before his nap is not the time to take down his electric train set from the closet and lay it out on the living

room floor. Who could blame him for not wanting to be dragged away to nap 15 minutes later?! Let him play with a jigsaw puzzle, color in a coloring book, or engage in some other quiet activity that, though interesting, isn't compelling. And, of course, don't give him a sugary snack right before he's due for a nap.

Steps You Can Take

Kids thrive on routines. Yes, you may know a family in which the kids don't have a fixed bedtime or naptime (or mealtimes), everything is done "when they're ready," and the kids thrive on it. But we all know there are exceptions to every rule. And the rule is that kids do well with a good amount of structure. Even if the child can't tell time, if naptime is usually about half an hour after lunch, the child will have some kind of feel for the fact that it's getting close to naptime. And he'll have less grounds to resist napping. He knows what's expected of him and when.

You can make naptime more enticing if you couple it with an enjoyable activity. You probably read your child a story at bedtime (or have some other pleasurable bedtime activity – singing to her or with her, or talking about the highlights of the day to put her in a good frame of mind before she goes to sleep). You can offer her a similar pre-nap activity too. Again, this might be reading a book or telling her a story, singing songs to her or with her, or even playing a quiet, gentle game... something that doesn't involve physical activity, isn't overly stimulating, and won't get her all excited.

Drawing his blinds can help on two levels: First, by darkening the room you're subtly suggesting that it's time to sleep. And second, by closing the blinds you are blocking his view of the outside. If his bedroom window looks out on anything that has the potential to be exciting or engaging, you'll do well to cut off his view of it when you want him to sleep. Whether it's birds, squirrels, passing trucks, neighbor kids at play, or some other absorbing view, eliminate the distraction so there's one fewer thing to hold his attention and keep him awake.

If he has a favorite stuffed animal, by all means let him snuggle with it till he drifts off. If he still uses a blankie, let him hold the blankie when he goes in for his nap.

You Both Need Naptime

A child who doesn't get a needed nap is a child who's going to be cranky for much of the afternoon... and who's likely to run wild, out of control. Too, he may be difficult to get to bed in the evening. Though you know he needs his sleep more than ever that night, due to overtiredness he may have trouble falling asleep when you do get him to bed.

But he's not the only one. You need his naptime too! Some mothers use their kids' naptimes to take a very much-needed nap themselves. Others use the time for tasks and other activities they can't or would rather not do when the child is awake. Paying bills: You don't want to make a mistake in the checkbook, yet it's hard to concentrate with an active two year old in the room (and even harder to concentrate when he's out of the room and you're wondering what he's up to). Sewing: You may not want to have pins and needles where the child can get to them if you turn your back or get up to answer the phone. Cooking: You might want to do some advance work on dinner if you can, especially the parts of dinner prep that involve the use of sharp knives. Talking on the phone: Whether you're calling the electric company to question the size of your last bill, and you want to be able to talk uninterruptedly, or you're calling your best friend and have something to tell her that isn't suitable for your child to hear, naptime is a good time for those calls.

When She's Really Outgrown Naptime

But there will come a time when she truly has outgrown her need to nap. It won't happen all at once. She may need naps some days and not others. But you may find that you put her to bed and then hear her tossing restlessly, unable to fall asleep. Or she may protest that she doesn't need a nap anymore, and your maternal instinct tells you that this time it's for real. She's not just trying to be a big kid; she really is growing, and she just may have outgrown her need for naps.

At first you can try mandating a "quiet time." You won't insist that she nap, but she needs to lie down and rest. Perhaps you'll let her engage in a quiet activity while she's lying down: looking at pictures in a book, perhaps, or listening to soft music. She may still fall asleep during quiet time on occasion, but more and more, she'll remain awake. And, when you see that she really isn't napping anymore, you might consider not even insisting on quiet time. Though at that point, you may want to start putting her to bed half an hour earlier.

Weekend Warriors

Of course, if she attends daycare or preschool, napping at home is an issue only on weekends and school holidays, but until she's old enough to give up her nap, you still want to get her settled into some sort of napping routine. And that's harder on weekends. You have activities you want to take part in and places you want to go. Whether you're taking her with you while you go grocery shopping, doing a raft of other errands, visiting Nana or a friend, or attending some sort of family-oriented event, there are places you want to go and things you want to do. But try, whenever possible, to

plan your day so that your child is home at something close to her usual naptime, to preserve that routine as much as possible. It may make the difference between having a calm, pleasant rest of the day or a zooey one. And it will help reinforce the fact that half an hour after lunch (or whatever the rule is in your house) is naptime, so your child will put up less resistance in the future.

Author of over 50 published books (and still going strong), Cynthia MacGregor writes on many subjects, but

the majority of her books are aimed either at parents or at kids. Some of her books tackle “difficult” topics, such as two books written for kids that explain divorce and one that deals with stepfamilies, one for little kids that explains death, and another for little kids that explain’s Mom’s new pregnancy. But she also writes on happier subjects, as in The I Love You Book, and with a sense of humor when it’s called for, as in What Do You Know About Manners? A former New Yorker, Cynthia has lived in South Florida since 1984.

Temper Temper - Dealing with Your Toddler's Tantrums

By Caron B. Goode, EdD

Temper tantrums are a part of growing up. As your child moves from babyhood to toddlerhood, she learns at an extraordinary pace. She is literally learning something new everyday. Unfortunately, her cognitive and physical skills are often times not in sync. This leads to frustration, which leads to temper tantrums.

Your toddler has tantrums for a number of reasons. Her pants itch. The puzzle piece won't fit. You gave her milk when she wanted juice. Since they are still learning to talk, toddlers have a hard time expressing their needs. It is very frustrating for them to want something and not be able to get it. This, coupled with their limited problem-solving skills, leads to tantrums.

To parents, these emotional outbursts often appear to have no rhyme or reason. Many times they don't. Many other times your adult reasoning stands in the way. With good cause. When she takes a flying leap off the stairs, you see broken bones and hospital visits. She sees something else entirely. She sees an opportunity for fun. But you are denying her the fun, and she becomes frustrated.

For most children, temper tantrums ease off with maturity. Once their speaking and reasoning skills improve, children no longer need to have tantrums. In the meantime, it is important that parents establish a consistent way of dealing with them. By doing this, you show your child the importance of clear communication and emotional control.

Dealing with Temper Tantrums

- **Cooler Heads Prevail.** It is important that parents remain calm in the midst of a tantrum. It goes without saying; these episodes can be as frustrating for you as they are for your child. But remaining in control of yourself and your emotions sets a positive example. It shows your child that you value calm communication and conflict resolution.
- **Think Before You Act.** There are many ways to handle temper tantrums. Take a few seconds to evaluate the situation before you decide on an action. You may be able to distract your child. Replace a dangerous plaything or activity with a safer one. Remove your child from a room or group to escape over stimulation and calm down. Each temper tantrum calls for its own action. Be sure to think before you act. This can mean the difference between soothing and escalating her frustration.
- **Give Her Frustration a Nod.** Acknowledge your child's frustration without condoning the tantrum. This validation can have a soothing effect. Let her know that you understand she is upset, but also let her know there is a better way of handling it. Then when she calms down, give her those tools. Show her better ways of expressing her wants and needs.

- **The Talk.** Do not try to talk or reason with your child when she is in the throes of a tantrum. It does not work. It also increases both your frustration levels. When the temper tantrum has run its course, discuss her behavior. Use this time to teach her positive ways to handle anger and frustration. Give her phrases to use when asking for help and sharing her emotions. In time, she will begin to express her needs in a manner that is more productive and clear.
- **Hold On.** An out-of-control child can be a danger to herself or others. If this is the case, calmly take your child into your arms until the tantrum subsides. Speak to her in a soothe voice. Acknowledge her anger and tell her you will hold her until it passes. This approach is often very comforting to children. The fact is, they don't like to be out of control. It scares them. It also makes them feel more secure to know an adult is taking the situation in hand.
- **Head Them Off.** By studying your child's tantrums, you may identify certain patterns. This can help you avoid some trigger situations. Ask yourself when and where do they occur? What happens directly beforehand? Are specific people present? Use this

information to keep tantrums to a minimum. Also, having a routine and reasonable limits helps children know what to expect. When they know what to expect, they are less likely to be taken off guard emotionally. In addition, carefully monitor your child's activities. Do not present her with tasks that are above her skill level. This will only lead to frustration, which leads to tantrums.

- **Offer Comfort.** Tantrums can take a toll on children. Often, when it is over they are not even sure why they were angry in the first place. Offer your child a warm hug and some reassurance. Let her know you disapprove of tantrums, but that you love her.

*Dr. Caron B. Goode is the founder of the Academy for Coaching Parents International, a training and certification program for parent coaches. In addition to duties with the academy, Goode is the founding editor of the website InspiredParenting.net, and the author of eleven books, the most recent of which is *Help Kids Cope with Stress & Trauma*, which includes several chapters on her use of storytelling strategies. For more information on The Academy for Coaching Parents International or to sign up for academy announcements, visit www.acpi.biz.*

Working Parents Can Overcome Homework Hassles

By Raymond J. Huntington, PhD

Parents and caregivers are constantly reminded of how important it is to pay attention to children's homework habits. But what if you're a working parent who can't always be home to ensure that the work gets done?. If that's the situation you find yourself in, the following tips should provide the kind of guidance that fills the gap.

Step One: Renew the Expectation of Excellence

Now, as always, it's important to verbally communicate your expectation that your son or daughter will complete all the homework that's assigned, and create a structure that paves the way for completion without constant supervision. Begin by setting up a time, every day, when homework is supposed to begin. If you're at the office, call home, every day, at that exact time. Ask your child about his or her day. Ask for specifics about what was assigned, and then state, "Okay, before I come home, here's what I want you to get done."

Step Two: Help Your Child Stay on Track

The second step, which works well with the first, is to create a Time Chart for the hours in which homework should be done. Break it down into half-hour increments. Have a copy at your desk at work and make sure your child is reviewing the same chart while you walk through it over the phone. Make it clear that "between 3:30 and 4:00 you'll be working on this; between four and five you'll be working on this," and so on.

The operative principle here is to set an expectation, and then make it clear that the expectation must be met by a deadline. But it's really more practical than punitive. By talking through the assignments in a non-confrontational way, you're breaking the homework down into bite-sized pieces, making sure your child has a clear understanding of what needs to be done, and a structure for managing her time.

Step Three: Make Study Time the Right Time

In addition to ensuring that homework time is free of the distractions of television, leisure “web” surfing and phone calls with friends, try to arrange the schedule so that your child is concentrating on assignments when he or she has the energy and mental clarity needed for optimum performance. Some students may do best by delving into homework as soon as they get home from school, while others may need some time to wind down before they can focus.

It's also important to make the most of concentration and energy cycles. For example, most students have one or more subjects that they find especially difficult. Because homework in these subjects tends to demand sharper concentration skills, students should try and take them on when they're most alert. Getting the harder work out of the way before going on to easier assignments alleviates anxiety and helps students avoid being caught in a late night trap in which the work becomes more difficult because of fatigue and frustration.

Step Four: Become a Better Homework Partner

During the early grades, your child may have grown accustomed to doing homework with your active coaching and encouragement, but middle and high school homework often lends itself to independent study whether or not one or both parents are at home. Yet you can still be an active partner. If your child has a particularly difficult assignment that requires your help, he or she can save that assignment for a time when you're available. If you simply can't be home, talk with your child's teachers about special after-school mentoring programs and study sessions that

will ensure your son or daughter gets the extra help and support to succeed.

Step Five: Help Your Child Become More Study-Smart

Efficiency is one of the most important tools in your child's learning arsenal, and simple study “tricks” can help your child get more work done in a shorter amount of time. Teach your child to find important information in a chapter quickly by paying close attention to introductions, headings, bolded phrases and summaries. As students read through material, it can be helpful to pause on occasion and summarize what they've read. After reading a few paragraphs, for example, restating the main idea and key points in their own words can help students retain and organize the information.

Students should also remember that diagrams and tables in textbooks are often used to clarify main ideas – and are also good indicators of information that the author (and a teacher) may consider important.

Step Six: Remember It's Not Just About Homework

If you're like most people, your work day requires you to get a lot done before you head home. Your child likewise has a limited number of after-school and evening hours for homework, extracurricular activities and “down-time” before the lights go out. By helping your child budget his or her time now, you're setting a pattern for habits that will enhance success in the classroom and workplace alike.

Dr. Raymond J. Huntington and Eileen Huntington are co-founders of Huntington Learning Center, which has helped children achieve success in school for 30 years. For more information about how Huntington can help your child, call 1 800 CAN LEARN.

A Few Words from the Editor

Pediatrics for Parents is changing – and you are reading one of the changes. The PDF version of the newsletter now includes articles that are not in the printed version. These articles are a little less medical in nature, but still contain useful information. All the articles are written by experts in their fields.

If you haven't checked out the podcast you should. Each podcast includes an in-depth interview with a *Pediatrics for Parents* writer. Other regular features include Drs. Alvin Eden and Roy Benaroch who answer your questions, Vikki Sloviter who reviews the latest

in children's safety news, and Elizabeth Pantley who provides a parenting pointer. You can download the podcast from iTunes or from the *Pediatrics for Parents* website.

I value your opinions. You can send me your comments and questions to richsagall@pedsforparents.com or leave a message at 973-302-8187.

Look for another issue in a few weeks.

– Rich Sagall, MD, Editor and Publisher